HEALTH EMERGENCY

Bulletin of Hands Off Our NHS * No.58 * Autumn 2003

A SPECIAL 12-page 20th anniversary issue

INSIDE

Hear **ALLYSON POLLOCK** and **TONY BENN** at LHE's **20th Anniversary meeting** – see p3

Oxford could be eye of new storm against DTCs

Staff at Oxford's Eye Hospital, situated in the city centre Radcliffe Infirmary, have decided to mount a campaign to defend its services against possible cuts and closures.

The threat to the specialist service which covers a wide catchment population throughout the Thames Valley stems from the announcement of plans to open a new, privately-run Diagnostic and Treatment Centre to deal with over 7,000 day and outpatient cataract operations over a 3.5 year period – patients currently treated in the Oxford NHS unit.

Under the government plans, the cash (around £750 per case) would follow the patients – leaving the Eye Hospital with just HALF its current £5m a year budget, but retaining the responsibility to care for thousands of more serious and chronic eye conditions which do not offer easy profits to the private sector.

The Eye Hospital had already put plans in place to meet the government's tough new targets on reduced waiting times, and the local Primary Care Trusts have made clear their preference to keep services where they are.

The decision on DTCs has been forced upon Oxford from national bureaucrats at the Department of Health bureaucrats, who have demanded local health chiefs toe the line.

Ministers have given a commitment to establish some 26 privately-funded DTCs, and is now insistent that cash must be diverted from existing

(continued on page 2)

Modernisation? These hospital support staff at Whipps Cross Hospital have had to stage strikes to persuade contractors ISS Mediclean to break from Victorian working practices and agree to raise their wages to the level of NHS staff.

Market system, competition, private providers, Foundation hospitals …

BACK to the future?

Forward – or back? Health Secretary John Reid

THE VOTE AGAINST Foundation Hospitals at Labour Party conference was no freak result. Ministers already knew that their plan to give the best-resourced and best-performing hospitals even more resources and more freedoms at the expense of non-foundation Trusts was highly unpopular.

Indeed the process of establishing foundation hospitals has already been dropped in both Sweden and in Spain after the first few experiments went sadly wrong.

The foundation Trust idea has been opposed by organisations representing almost all sections of health workers, by other trade unions, by patients' groups and by a vast percentage of Labour MPs who are not on the ministerial payroll.

This opposition isn't opposition to more local control and flexibility in the NHS: it comes from the bitter experience of NHS Trusts, which the Thatcher government insisted were supposed to deliver precisely the same result.

And people are even more wary because the new Foundations would be encouraged and empowered to act more like private businesses – doing more deals with the private sector, competing with other Trusts for contracts to treat NHS patients, and so n.

To open up the space for Foundation Trusts, ministers are effectively re-creating a new, competitive market system within the NHS. We are told that this represents "modernisation".

But markets aren't new or modern: they have been around as long as capitalism.

What was new was the post-war concept of a publicly-owned, publicly-run welfare state, in which a range of vital services were effectively removed from the market – and run for the benefit of service users, provided free rather than as commodities sold for profit or personal gain.

A genuine modernisation of the NHS would build on this foundation, ensuring that the new funds injected were spent in the most cost-effective way within the public sector – and moving towards more local control and accountability.

This means empowering health workers and local service users, by establishing elected health authorities and giving elected trade union reps a genuine voice in shaping policy at every level.

Foundation Trusts and market reforms head in the opposite direction, empowering accountants, bureaucrats and private profiteers.

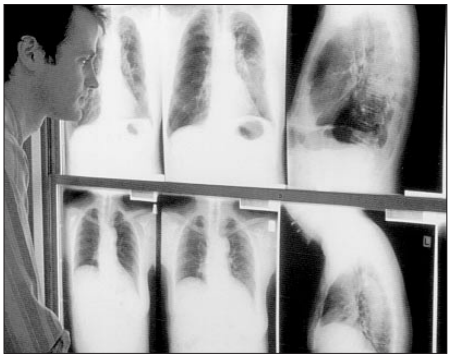
Despite the bureaucratic costs of the Thatcherite market-style reforms, the NHS has remained one of the world's cheapest to run. Plunging waiting times show that where sufficient resources are put in, the system can deliver.

So why do ministers want to drag us back to more expensive, discredited, old-fashioned market models more suited to Victorian mill-owners than a 21st century public service?

London Health Emergency is now celebrating 20 years of campaigning to defend and extend the NHS: strangely it is us, and our colleagues in the unions fighting for this principle who are denounced as dinosaurs – when it is the so-called "modernisers" who are dragging us back to the failed systems of the past.

Mental health Trusts' cash crisis – p10

DTCs: turning your NHS into a nice little earner



WHEN is a private hospital not a private hospital? When it is an Independent Sector Treatment Centre – the coy new official government-speak for a chain of 26 privately-owned and run units previously known as Diagnostic and Treatment Centres (DTCs).

But while 20 NHS-run DTCs have been quietly established and are on course to operate successfully, the kernel of the government plan, unveiled in 2000, was to allocate a substantial share of the routine elective (non-emergency) surgical and diagnostic work to the private sector.

Alan Milburn's NHS Plan always centred on creating a new "partnership" with the private sector – the same private sector that routinely poached NHS-trained nursing and medical staff, and which "cherry picks" the patients and the procedures which offer the most profits, leaving all of the costly, long term and intensive treatment to the NHS.

Milburn's "partnership" began with the "Concordat" which proposed a greater use of private sector hospitals to provide treatment for NHS-funded patients – siphoning cash from the budgets of the Trusts which were already struggling to cope with local demand.

It was grasped as a lifeline by a private sector which was carrying vast numbers of under-used beds. A whole BUPA hospital in Redhill in Surrey was effectively hired to deliver treatment for NHS patients – though the costs of this deal have never been publicly revealed: BUPA's standard costs for routine operations are well above those in the NHS.

But the private DTCs were to be different: they were to be new units, set up and run from the outset by the private sector – and under the original specification, they were supposed to bring all of the necessary staff with them, making no demands on the local pool of qualified health workers. This meant that many of the corporations submitting bids have been overseas or multinational companies.

They were supposed to ensure "additional clinical activity, additional workforce, productivity improvements, focusing specifically on additional capacity."

"It will be a contractual requirement for providers to define and operate a workforces plan that makes available additional staff over and above those available to the NHS. … We recognise that additional costs may result from our requirement for the independent DTC to provide staff that genuinely add to the NHS workforce … We will recognise these factors in our evaluation of value for money" (DoH *Growing Capacity*). In fact none of this has happened.

DTCs have now been told that they are free to recruit up to 70% of their staff from the NHS – potentially stripping local hospitals of the staff they need, and lumbering them with sky-high bills for agency staff to fill the gap.

The profit-seeking DTCs will scoop up a share of the projected caseload of 250,000 procedures a year which would be delivered in this way – 135,000 extra operations, and 115,000 treatments diverted from existing NHS units.

Their profits are guaranteed. The nationally-negotiated contracts are to be drawn up on a "play or pay" basis – meaning that the PCTs are required to pay the full contract price to the DTCs over the 5-year period, even if the NHS sends fewer patients for treatment.

Of the preferred bidders announced in September, five are from overseas – from Canada, South Africa and the USA, and two British.

They will treat only non-urgent cases where waiting times have been a problem, including orthopaedics (hip and knee replacements), ophthalmology (mainly removal of cataracts) and minor general surgery such as hernia and gall bladder removal.

The private units will have no obligation in terms of after-care: and they will be able to fix their own terms and conditions: it is already clear that they will be offering consultants four or five times the amount currently paid to NHS consultants.

While Ministers claim DTCs will be paid the same cost per case as NHS hospitals, it is clear that they will concentrate on the most profitable and simple cases, leaving the NHS with an increasingly expensive caseload.

And the DTCs start-up costs will be subsidised – giving them a greater chance of generating a surplus.

Unlike NHS units such as the Oxford Eye Hospital, where the revenue from cataract operations helps underwrite the running costs of a department delivering a full range of services, any surplus created by DTCs will simply be pocketed as profit by shareholders.

The opposition to the plans has been widespread. Private hospital chiefs are miffed that new units are being built instead of filling up their existing empty beds. Tory shadow health minister Liam Fox has said the contracts are too expensive.

Almost all organisations representing health staff have opposed the new private centres: UNISON warned that they will drain resources and staff from the NHS. The BMA has said that the DTCs could destabilise the NHS.

The Association of Surgeons in Training warned that the centres could do lasting damage. Even the Royal College of Nursing expressed concern over staffing levels.

NHS units have responsibility for training doctors and nursing staff, and need to maintain a broad mix of routine and more complex cases to ensure that junior doctors gain the necessary experience: DTCs by creaming off a large share of the routine work will disrupt this balance, while simply poaching the staff already trained.

To make matters worse, despite the talk of an NHS Plan, the proposals for DTCs have run alongside government targets and pressure on local Primary Care Trusts and Hospital Trusts to reduce waiting times to a maximum of 6 months by 2005. There has even been an injection of new funds into the NHS to enable it to expand its own capacity.

Now, just as some of these investments are starting to deliver, a small group of bureaucrats at national level have announced where the new private sector DTCs are to be. Only bankrupt Bristol PCTs have been allowed to back out: other local health commissioners have been given no say: and in the case of Oxford ophthalmic services the PCTs that have objected have been slapped down.

The companies set to coin it in from 5-year contracts to run DTCs are:

- Mercury Health Ltd – a British based company (9 centres)
- Birkdale Clinic – British-based private clinic, gets one centre at Daventry
- Anglo Canadian – 3 clinics in London
- Nations Healthcare – a US-led consortium (2 centres in Bradford)
- New York Presbyterian – 2 centres, Stanmore and Somerset
- Netcare UK – a South African company – will run a centre in Manchester and two mobile ophthalmology units
- Care UK Afrox – a link-up between Care UK, which runs nursing homes, and Afrox, a British Oxygen subsidiary running 60 private hospitals in South Africa –3 centres.

Oxford Eye Hospital fight

(from front page)

NHS services in order to guarantee 5-year contracts with the private corporations running the Diagnostic & Treatment Centres and other Private-Public initiatives.

Angry health workers responding to the attack on the Eye Hospital have agreed to build a big public campaign in Oxford to increase pressure on the government - targeting local MP and cabinet member Andrew Smith in particular - to force them to back off on their privatisation project.

The campaign will initially be based among workers in the Eye Hospital with a meeting on October 9, which it is hoped will plan a big public meeting and

The Oxford crisis

New private DTC is not needed!

Oxford Eye Hospital has been working to a plan of expanding its capacity to treat cataract and reduce waiting lists to 3 months by December 2004. Consultants point out that there is "no capacity gap in Oxfordshire … in fact we can demonstrate over-capacity". A DoH document on Capacity Gaps last December made to reference to Oxfordshire.

Rather than providing extra capacity to treat additional patients, the new DTC will transfer up to 50% of NHS cataract patients into the private sector, at higher cost.

According to top consultants at the Eye Hospital, the consequence is likely to be:

- Restricted ability to screen and treat patients with other eye problems, many potentially more sight threatening than cataract
- The Eye Hospital would be left with a more complex and expensive caseload
- Withdrawal from outreach clinics in surrounding towns (Banbury, Wantage, Abingdon, Bicester and Witney).
- A loss of specialist corneal diseases services – meaning patients will have to travel to London for treatment
- Questions over the viability of on-call services, A&E services and specialist services
- Training and research – which requires a minimum caseload – restricted, with the danger of losing accreditation for training
- Impossible to recruit a Professor, undermining the academic department
- No choice for patients, since the full DTC contract would have to be paid for, regardless of how many treated
- Redundancies among nursing, admin and other staff.

Under orders

Department of Health bureaucrats have shown no sympathy with the problems facing local Trusts and PCTs.

A stiff circular dated August 21 tells them they have less than a month to tie down any unresolved problems and sign up for the new DTCs.

As if to reassure them, the circular insists that it is not true that the ophthalmic surgeons to work in DTCs will be paid £450,000-£500,000 per year "as some clinicians have decided to assume when reading the pricing proformas and spreadsheets".

"These staff costs include the add on costs such as pensions, admin, travel, etc."

In other words the package for these doctors will be very close to £450,000. "In reality the ophthalmic surgeois are probably paid more than those currently in the NHS but they work a lot harder for it"!

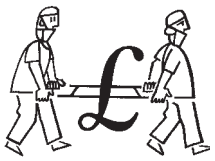
Cardiac chaos!

IN ANOTHER example of chaos in the NHS, it appears that capacity for heart surgery has expanded faster than demand – leaving some highly expensive surgical units searching for patients.

Waiting times have fallen as more resources have been pumped into the NHS, reducing numbers waiting more than six months for heart surgery from over 4,000 two years ago to just 375 this summer. By December it is likely to be zero.

In London the 95-bed Heart Hospital, controversially bought from the private sector by University College London Hospitals Trust, has run out of work: UCLH bosses recently volunteered to treat the entire national cardiac waiting list over 6 months.

The success story on slashing waiting lists combines with a longer-term problem as ministers once again reject any concept of planning and instead carve up the NHS into a "market" of competing units slogging it



out for contracts.

New medical treatments have reduced the need for heart surgery: but at the same time new resources have increased capacity.

It makes no sense to have staff in specialist units twiddling their thumbs – but even less sense to press relentlessly forward with market-style reforms that promise more of the same.

Down the road from the empty cardiac beds at UCLH, health chiefs are planning the country's first £1 billion hospital development – which will also offer heart surgery, combining the Royal Brompton and Harefield hospitals.

Perhaps somebody from the Department of Health should have a word about their dodgy prospects before they sign on the dotted line?

Confusion reigns as ministers axe CHCs

With Community Health Councils due to close in December, and many CHC staff leaving early to find alternative jobs, the plans for the government's alternative structures to replace them are a total shambles.

A recent survey of the so-called "Patient Advocacy and Liaison Services" (PALS) across the country showed that less than a third could offer an immediate and satisfactory response to even a simple patient enquiry.

Of 100 Trusts which claimed to have a PALS service in place, in only 87 did the switchboard connect a caller correctly to the PALS service. Only 51 of these calls were answered by a person rather than an answerphone: and of these only 28 could answer the simple question.

Trusts are only obliged to fund a minimum of one member of staff in a PALS service – well short of the extensive and professional support available from the best CHCs.

Meanwhile the establishment of a network of new Patient and Public Involvement Forums, to be set up in local Primary Care Trusts, is only just getting under way, with a half-baked campaign boasting chicken which demands "make time for health".

They won't need to make much time: Foundation Trusts will not have PPIFs, and since all Trusts are allegedly going to be Foundations within five years, they will probably have a shelf life not much longer than real chickens.

■ Meanwhile the Boy Scouts are among the ragbag of 140 voluntary sector organisations that have been given contracts to provide admin support for the new PPIFs.

Others include Citizens Advice Bureaux, charities such as Age Concern and a new organisation formed by a former CHC chief executive.

'Scout Enterprises Western Ltd' will provide services for 20 PPIFs in southern England.

Camp fires and woggles will no doubt be available on demand, while ministers are left to grip the NHS by the ging-gang goolies, and health workers struggle by on little more than a Bob a Job.

Merton & Sutton TUC

■ Fighting to defend full services at both Epsom and St Helier Hospitals

■ Congratulations to London Health Emergency on 20 years campaigning for the NHS.

President: **MAISIE CARTER**
Secretary: **KEVIN O'BRIEN**
Treasurer: **HILDA WETHERELL**

Foundation Hospitals, private Diagnostic and Treatment Centres, PFI, LIFT, financial flows …

Dragging the NHS BACK to MARKET

What can campaigners do to stop the rot?

Come and hear
- **TONY BENN**
- Prof **Allyson Pollock,** University College London
- **Margie Jaffe**, UNISON Positively Public campaign
- **John Lister**, London Health Emergency

*A special meeting to mark the **20th anniversary** of the launch of **London Health Emergency** as an independent organisation campaigning for the capital's health services.*

It will look forward to the next stage of the fight to defend services and health workers against growing inroads of the private sector and a new market system, and uphold the principles of the NHS as a public service provided free at point of use and funded from taxation.

THURSDAY
October 16
7.30pm **Friends House**
Euston Road WC1
(opposite Euston station)
Open to all, especially health workers and campaigners

Contact London Health Emergency:
Unit 6, Ivebury Court,
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London W10 6RA
020 8960 6466
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Nursing home bossess bid to jack up fees

Social services braced for "bed-block" fines

CONCERN is growing among council chiefs whose social services face fines if they fail to deliver additional services to facilitate the swifter discharge of frail older patients from hospital.

The latest estimate suggests that 3,500 of the frailest older people aged over 75 are currently trapped in acute hospital beds for lack of suitable alternative accommodation or supporting services.

Many of these patients have complex needs, requiring nursing home care.

The new fines are operating in "shadow" form from October, and due to come into force in earnest from January 2004. Councils will have to pay a daily fine of £100 (£120 in London) for any person who has been assessed as ready for discharge from hospital but not found a place in a nursing home within three working days.

Councils have been given just £50m nationally to allow them to expand preventive services and also to secure additional accommodation – and ministers claim that many should be able to pay less in fines than they receive in grant.

However the fact that nursing homes are in the private sector, and mostly run for profit, means that neither councils nor the NHS can fully control the numbers of places.

Far from opening more places, many nursing homes are closing down and selling up, while others are holding out for increased weekly fees from councils for the clients they accept.

Analysts Laing & Buisson estimate that more than 13,000 nursing home places have closed in the last 15 months, leaving the country with 74,000 fewer places than in 1996. Some councils in areas of severe shortages are reportedly investigating the prospect of opening homes themselves.

In Suffolk, nursing homes proprietors, spotting their bargaining strength in the new situation, are demanding an increase of £35 on the current council "benchmark" fee of £385 per week: in Norfolk the demand is for an extra £20 per week. And nursing homes are weighing up the chances of playing off NHS Trusts against social services departments to bid up the going rate.

The problems have been compounded by the lack of investment in modern information systems, facilities, and sufficient social workers to support the "single assessment process" that is supposed to bring together relevant professionals – social workers, nurses, therapists and housing officials – to gauge patient's needs and prepare the process of discharge.

■ Meanwhile members of the Royal Commission which three years ago recommended the abolition of all charges for older people receiving continuing care in nursing homes in England have reiterated their call on the government to implement this policy in full: at present clients receive only limited nursing care funded by the NHS, while "social care" is still subject to means-tested charges.

News BRIEF

IF AN AGENCY nurse starts asking patients "do you want fries with that?" they may have taken their tone from the new chief executive of the NHS in-house agency NHS professionals.

Carmel Flatley who has just taken on the job is a former vice-president of burger chain McDonald's. Ironically it is the burger bar-style rapid turnover of nursing staff in the NHS that creates the growing need for agency staff.

NHS Professionals has had a rocky start: it claims to have 47,000 staff on its books, but in some areas it has become notorious for failing to deliver staff as promised.

Its Yorkshire division, run bizarrely by West Yorkshire Metropolitan Ambulance Trust was found earlier this year to have run up debts of £10m.

Maybe it's just time for the NHS to "go large" and "max" the pay of in-house staff and to offer staff overtime rates, rather than resort to more costly and chaotic use of agency staff?

HAMPSTEAD'S Royal Free Hospital Trust is staring down the barrel, with a projected year-end overspend of £4.5m, even after implementing a cuts package.

Among the measures already

put in place to bridge the spending gap, Trust bosses have agreed to dip into capital funds to switch £1.75m to revenue, and negotiated additional £1m handouts from the Strategic Health Authority and the local Camden PCT.

Cuts which might reduce the deficit to £3.5m had been identified by September, but finance chief Peter Commins warns that further cuts totalling £2.2m would hit patient care, or in the jargon of today's NHS "the majority would have a serious impact on access targets".

EALING council in west London has run up an estimated £5m overspend on its social services, driven by factors including above-inflation rises in nursing home fees.

A package of service cuts and increased charges is being imposed.

Ealing PCT is struggling to resolve a £6m deficit in its commissioning budget, which could have a major impact on therapy services and community nursing.

Neighbouring Hammersmith PCT is facing a £5m shortfall.

THE FINANCIALLY and managerially-challenged Barnet and Chase Farm Hospitals Trust is trying to placate a nervous local public as it seeks to "rationalise" hospital services across a sprawling and congested catchment population in NW London.

The Trust needs to clear a massive inherited debt and improve performance: but Trust bosses want to replace Chase Farm with a new PFI-funded hospital, while avoiding "duplication" of services at Barnet, 5 miles away.

Barnet General hit the headlines in the mid 1990s when its PFI-funded Phase 2 rebuild forced the controversial closure of Edgware General Hospital as an acute unit.

BOSSES at Hillingdon Hospital, west London have been forced to board over a garish 30 foot long yellow orange red and pink mural painted on the wall in the hospital entrance – costing £25,000.

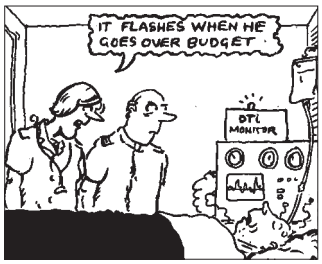
One female consultant complained that it gave her a headache: others have been outraged at the cost of the art, which is strongly reminiscent of graffiti routinely scrubbed off the carriages of tube trains.

CARILLION has won the contract to build a new 1,200-bed PFI hospital in Portsmouth. Though the final deal has not yet been concluded, the project will cost a minimum of £1 billion over the next 33 years.

The successful 1994-5 fight to save the A&E at Central Middlesex was part of a London-wide campaign backed by London Health Emergency

The essential points about Foundation Trusts

■ Foundations will "opt out" of control by strategic health authorities and the Secretary of State.
■ This is part of a wider market-style reform.
■ The first wave is expected to begin with up to 29 Foundations, but all Trusts are promised the right to opt for Foundation status.
■ Foundations will be "not for profit" companies (or "public interest companies"): this opens the possibility of private "non-profit" organisations (such as BUPA) bidding for Foundation status.
■ Foundations will nominally be run by a Board of Governors, but in reality control will remain in the hands of the unelected Management Board, which will be composed of existing and new full-time directors.
■ Funding for foundations and for other Trusts will be dependent on winning contracts from Primary Care Trusts, on the basis of work done (on the principle of the "cash following the patient") — giving an advantage to the best-resourced Trusts, but also pushing Foundations into competition with neighbouring Trusts.



■ Foundations will be obliged as businesses, and to balance their books.
■ Foundations will in theory not be allowed to expand private medicine, although some are already rushing through expansion plans before they get Foundation status, and others are looking to work with private medical companies.
■ Foundations, like Trusts will be free to retain surpluses, but Gordon Brown has pointed out that the government would ultimately be obliged to step in and bail out any Foundation that ran up huge losses.
■ Foundations will be free to fix local pay and conditions for staff, replacing national pay scales, although they are all likely to begin next April from the framework of the new Agenda for Change system, which ministers want to operate throughout the NHS from the end of 2004.
■ Original plans giving Foundations freedom to borrow in the private markets were effectively abandoned. Instead their right to borrow will be subject to the decisions of a new "independent" regulator.
■ Any borrowing by Foundations will be from the total capital available to the NHS, so any preferential treatment for them will be at the expense of other Trusts.
■ Foundations will be subject to a "lock" on their core assets, preventing them from selling them or using them for non-health purposes without permission from the new regulator. Nor will they be allowed to mortgage their assets.
■ Foundations will have no shareholders to distribute profits to, but are expected to work in an "entrepreneurial" way – and are free to work 'in partnership' with private companies which can generate profits and give them to shareholders.

Not such a big deal?

Just 7% of NHS chief executives think foundation hospitals will be the most important policy change in the next five years, according to a Mori poll.

However two thirds of them thought foundation status would damage cooperation within the NHS, and almost half thought it would result in more freedom for managers.

The survey for the NHS Confederation put foundation status at the bottom of the list of important changes, which was topped by the Patient Choice policy.

The biggest management challenge was seen as achieving financial stability.

Markets may be OK for your fruit & veg and the odd Russian camcorder: but health care?

It's all about a new NHS market

Bosses at University College Hospital, London have been trying to placate local opposition from Camden residents and MPs from the surrounding area (including foundation trust opponents Frank Dobson, Glenda Jackson, Jeremy Corbyn and Chris Smith).

Chief Executive Robert Naylor went so far as to promise a meeting of Camden Primary Care Trust that the hospital would not undercut neighbouring hospitals (such as the Royal Free and the Whittington) or poach staff.

As puzzled listeners scratched their heads to work out why UCLH wants Trust status if not to beat the local competition, Naylor went on to argue that it would not be in the hospital's interests to draw more patients in to the hospital.

Is this the same Robert Naylor who was recently offering to treat the whole of the country's waiting list for cardiac surgery in a desperate effort to fill beds at the Trust's Heart Hospital (see page 3).

Survival

The reality is clear, no matter how much managers may deny it: foundation hospitals will be forced to compete with other NHS hospitals for staff, for patients and for revenue if they are to survive. That's what foundation status is all about.

And foundations will begin with an advantage, since they will be free to vary pay to attract extra staff, and will have additional powers to borrow – and to pick and choose the services they wish to market within the NHS.

Mr Naylor has been one of the NHS bosses pushing forward the move to foundation status, and making it clear that UCLH will seek deals with the private sector is their bid succeeds.

His two-faced story for local consumption simply demonstrates how much he has to hide.

So much for all that talk about democracy and local control ...

Not only do foundation trust applicants not know how much money they may borrow, they still don't know how they will run the new set-up, which ministers have claimed would involve thousands of local people becoming "members" – possibly at a fee of £1 per head.

The Co-op Party, which has argued that foundations are not a step on the slope to privatisation but trail-blazing "mutuals", has suggested memberships could reach as high as 50,000.

With some teaching hospitals drawing on a catchment population as high as 2.5 million, even this many members would be a small sample.

But UCLH boss Robert Naylor has argued that the £1 per member system would be impractical and is likely to be dropped – but failed to answer how the Trust would select a governing council of 40-60 local people and service users.

According to the Health Service Journal, his chair, Peter Dixon, has warned that the Trust could wind up "choosing between the Hampstead Heath Conservative Society and the local Trotskyists".

No it's not the finances, it's the level of public support for foundations

The Chair of Birmingham's University Hospital Trust has dismissed the idea of a 5,000-strong 'membership' for each Trust as "an absolute nightmare".

One of the architects of the foundations policy, Ed Mayo of the New Economics Foundation told a workshop that Trust bosses who wanted the freedoms offered to foundations should "go for as small and token a membership as you can."

In any event fresh questions over the value of membership and the so-called democratic element of foundations have been raised by the government's response to a critical report from the Commons Health Select Committee.

Ministers make clear that the board of governors would have no power to veto any action taken by a foundation Trust's directors, and will "approve" the appointment of the chief executive.

The governors will only elect the chair and the non-executive board members.

This has caused a flutter of anxiety among existing Trust chairs and non-execs concerned that they may lose their appointed seats – and the salaries and vol-au-vents that go with them – if they are forced to stand for election in even the most limited public forum.

Interestingly given all the rhetoric about increased local accountability, foundation Trusts – unlike other Trusts – will not be required to run patient forums.

Doubts over new rights to borrow

The rush to launch foundation hospitals is under way – even though the leading candidates are still in the dark over how they are supposed to run the new enterprises, or how much money they will be able to borrow.

One of the main selling points among the "freedoms" of foundation Trusts was the idea that they would be free to borrow money either within the NHS or from the private sector.

But when the Department of Health eventually published the formula on which the foundations could calculate how much they could borrow, there were howls of disappointment in the boardrooms: the totals were universally small, and in one case zero, according to the *Health Service Journal*.

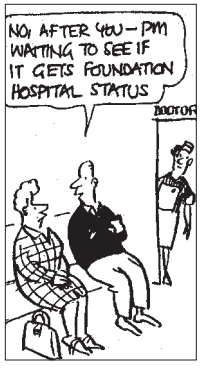
Foundation borrowing will also be strictly controlled by a new regulator, who will have far more power over their decision making than any of the tokenistic local bodies.

Managers are expecting the regime to be tough, and some are already playing down the borrowing issue, expecting to get little or nothing.

There are even fears that the regulator may conclude that the financial position of up to half of the potential first-wave foundation hospitals is too rocky for their application to go ahead: as few as 15 may make the grade.

But nobody knows. The code that will govern the regulator's actions will not be published until after the legislation establishing the new post has been carried.

Trusts applying for foundation status are therefore buying a pig in a poke: they don't know what they will gain, or what conditions they will need to satisfy to gain anything at all.



LHE: 20 years in the forefront of campaigning

You can pack a lot in to 20 years – and the pace was often frantic as LHE set out to make itself useful to local campaigners and union activists across the country.

We have too little time and space here to do more than refer to some of the landmarks in two decades during which LHE, working with a crucial cross section of union activists, MPs, councillors, pensioners and campaigners helped set the agenda and challenge every attack on the NHS and its underlying principles.

Our thanks go out to all those who have supported LHE, and helped us survive the various and repeated attempts to close us down. We hope we have sufficiently repaid the favour.

Chancellor Lawson's budget triggers wave of hospital closures and occupations

Health Emergency paper launched as a monthly, circulation 14,000

Exposee pamphlet "I was a Mole in Mediclean" published

London-wide demonstration organised by LHE, June 29

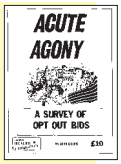
Strikes against privatisation across the country

LHE publishes London round-up "Hitting the Skids" - *Health Service Journal* comments: "The picture presented by London Health Emergency is of course presenting a picture of an area which does not exist in the health service. The London area on which it bases its figures is simply the innermost districts of the four Thames regions. "However there is a growing belief that the type of analysis offered by LHE is rapidly going to become where the goal posts will be placed as far as the London debate goes."

Winter 1987: LHE's consultants' petition against cuts backed by 1,200 doctors in 160 hospitals

Thatcher unveils White Paper setting out market-style "reforms": LHE launches 'Hands Off Our Hospitals' campaign, with slogan 'Tear up the White Paper'

Ambulance pay dispute drags on for over 6 months



As ministers rubber stamp 57 Trust opt-outs, LHE pamphlet analysing their dodgy finances gets national press coverage

Detailed survey of mental health services for health union COHSE highlights gaps in community-based care as beds close

LHE works with West Berkshire campaigners to fight closures of NHS geriatric beds

1983 1984 1985 1986 1987 1988 1989 1990 1991 1992

London Health Emergency formed with GLC funding to link campaigns and raise profile

Barking Hospital strike leads a wave of struggles against privatisation of ancillary services

200 attend LHE conference on fighting privatisation, backed by all main health unions

GLC abolished: LHE funding eventually taken on by a consortium of London boroughs

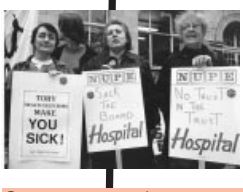
Save West London Hospital (SWEL) campaign launched

Maudsley hospital staff stage successful strike against cuts

Night nurses in Manchester walk out in unofficial strike over pay. Followed by unofficial strikes in London and around the country

LHE February 3 Rally draws over 1,000 health workers and campaigners to the Camden Centre

LHE warns new Griffiths Report on "Community Care" heralds more privatisation and means-tested charges



Campaigns across the country oppose hospitals "opting out" to form the first wave of Trusts. LHE distributes thousands of leaflets, stickers, car stickers and pamphlets

Detailed LHE drafted reply to hospital rationalisation plan stirs debate in Barking and Havering

LHE opposes King's Fund call to axe 5,000 beds in London's hospitals

LHE infuriates government by leaking key findings of Tomlinson Report to national press the night before publication

LHE and unions launch Londoners Need London's Hospitals campaign to fight Tomlinson proposals to close ten hospitals and 4,000 beds

Carlisle's Cumberland Infirmary: a smart new entrance – right next to the portakabin to supply extra beds

1993

Virginia Bottomley publishes plans to close hospitals over and above the Tomlinson closures: campaign stepped up to defend Charing Cross and Barts Hospitals

LHE reports highlight the threat to casualty services across the capital from hospital closures

TUC stages national demonstration on November 20: NHS Emergency Day

1994

1995

LHE drafts Acute Concern, challenging hospital closures and rationalisation, on behalf of ten councils throughout Hertfordshire

Government publishes new Eligibility Criteria for continuing care designed to exclude hundreds of frail older patients from NHS beds

Hands off London's Hospitals conference convened by LHE links campaigners across capital.

1996

1997

General Election brings welcome ousting of Tories: LHE offers assistance and advice to new Labour ministerial team – no reply. Labour councils begin to withdraw remaining funding from LHE. Tory cash limits still in force.

1998

Royal Commission reports on care of elderly, proposing care should be free at point of use, funded from taxation. Ministers silent

The Care Gap: UNISON London conference on mental health publishes LHE-drafted report and mental health workers' charter

1999

2000

2001

2002

2003

First PFI-funded hospital opens in Carlisle – immediately beset by structural problems and bed shortages

NHS Plan published, outlining 10-year plan to expand and improve services using large year-by year increases in funding. LHE welcomes extra cash but warns almost all new hospitals to be built using PFI – boosting costs.

LHE interviews staff in nine PFI hospitals for UNISON pamphlet *The PFI Experience: Voices from the Front Line*

Second mass distribution broadsheet for health branch of UNISON opposing Peterborough PFI hospital scheme

Health Secretary Alan Milburn pushes forward with plans for Foundation Trusts – and then resigns

LHE researches major report on Central Manchester hospital PFI for Community Health Council

LHE interviews staff at Swindon's Great Western Hospital for UNISON pamphlet on PFI

LHE's Fact Sheet on Agenda for Change distributes 50,000 copies to various unions. After heated debate, UNISON and Amicus/MSF vote overhwelmingly in ballot to allow early implementers to proceed and decide in 2004

LAS SOS: LHE researches campaigning broadsheet pressing for an extra £30m a year to fund the London Ambulance Service.

Dudley Hospital workers end long series of strikes against transfer to private contractors under PFI: projected cost of scheme doubles to £135m.

LHE researches dossier on PFI in the NHS for GMB

LHE drafts detailed analysis of Eligibility Criteria and local implications for UNISON branches and regions in Cambridge, Suffolk and East Midlands

LHE steps up campaigning and publicity work on the Private Finance Initiative: although introduced in 1992, it has not yet financed a new hospital, but brought building programme to a halt.

The Credibility Gap: LHE survey of the capital's mental health services, published by UNISON London Region

LHE works with UNISON and campaigners to fight hospital closures and rationalisation in West Hertfordshire

LHE helps advise Edgware Hospital campaigners pressing for new Community Hospital without PFI involvement

50th Anniversary of NHS: Health Emergency produces special full-colour issue.

LHE researches *Casting Care Aside*, Wyre Forest council's response to Worcestershire PFI scheme that could axe Kidderminster Hospital in-patient care.

6,000 march through Canterbury to oppose planned cuts in East Kent

LHE drafts *Red Alert* – report for Save Our Community Hospital Services in Oxfordshire

Edgware Hospital campaign commissions LHE to produce 50,000 tabloid newspapers in huge community-wide mobilisation against closure

Guy's Hospital campaigners march against closure

Battersea & Wandsworth TUC and the Workers Beer Company

From the "nasty borough" – the frontline of the fight against privatisation

Congratulations to London Health Emergency on 20 years campaigning:

- Against all cuts and closures in the NHS
- Against privatisation
- Against PFI
- For a publicly-owned, publicly funded health service
- For respect to all sections of staff in the NHS health care team

Organising Centre 020 8682 4224
www.respectatwork.org.uk

PFI projects push up bill to £1 billion:

Manchester faces up to "unaffordable" capital programme

NHS chiefs throughout Greater Manchester will have to choose whether to build and refurbish the area's hospitals and health facilities – or whether to meet national targets and National Service Frameworks laid down by the government.

If they attempt to do both, then even the extra money that is being allocated to the NHS under government plans will fall short of requirements, plunging local Primary Care Trusts into deficits which would add up to almost £100m in 2005-6, and peak at over £160m in 2008-9.

The cumulative shortfall across Greater Manchester could reach a staggering £732m by 2010.

That is the grim message from a confidential survey of the costs and implications of over 40 capital projects, with a total estimated cost of over £1.1 billion that are currently at various stages in the planning process. The survey, carried out by business consultants for Greater Manchester Strategic Health Authority, was leaked to London Health Emergency.

The SHA obtained reports from all the project teams at work in the area on the revenue consequences of each of their schemes (which range in size from the giant £422m hospital complex in Central Manchester, a £190m bundle of projects in Salford, and a new £150m hospital in Stockport, to small scale additions of wards or operating theatres costing £5 million and less) – and the varying cost of each plan for each of the area's 14 Primary Care Trusts.

This has been set against a projection of the likely increases in funding for each PCT, and the known pressures on the PCTs' budgets arising from cost inflation, existing commitments, and future plans and targets.

The SHA concludes that Greater Manchester will have unallocated growth money totalling £18m this year, rising to £120m in 2009-10, but that the cost of the capital schemes will outstrip this new money each year, creating a steadily worsening crisis. It warns:

"Capital investment aspirations unaffordable both short and long-term, despite significant revenue growth. … Choices need to be made between capital schemes, NSF plans and other investments."

Commenting on the findings, LHE's Information Director John Lister said:

"This disastrous scenario in Manchester shows the folly of government policy, which after decades of drastic underinvestment in hospitals and capital assets is now expecting Trusts to pull themselves up with their own boot-straps through the Private Finance Initiative, which lands the whole cost on Trusts' revenue budgets.

"This report confirms that PFI schemes like the new Central Manchester hospital complex cannot be afforded without wrecking other services in the area.

"Gordon Brown is balancing the books today by stacking up problems for years to come. He should inject government capital to fund these new investments."

The £420m PFI project for a new hospital complex for Central Manchester hospital and Manchester Children's Hospital Trust has been put on hold despite reaching Final Business Case stage.

PCTs in Greater Manchester pulled back from endorsing the scheme in the light of the shocking figures in the SHA report (above) and after circulation of a detailed analysis of the FBC researched for Central Manchester CHC by London Health Emergency. This underlined the mounting costs of the 38-year index-linked PFI deal, which would start with payments of £48m a year, but cost a total of more than £3 billion.

More expensive than the Dome: £1 billion price tag on Paddington PFI folly

St Mary's Hospital cheif executive Julian Nettel is gamely whistling in the dark as the cost of the controversial scheme for a privately-financed hospital complex in Paddington, to house the services from Harefield Hospital and the Royal Brompton has almost trebled to £1 billion from the previous published estimate of £360m.

An increased estimate of £800m came in a Press Release from the Paddington Health Campus Project, which claimed that the scheme has been endorsed by Health Minister John Hutton.

New government guidelines had required the original planned floor area of the hospital to be expanded by up to 20%.

But this brought the plan into conflict with Westminster Council's Planning Department, which sent Project Director Nigel Hodson a detailed 6-page response outlining a long list of objections to the proposals, which include adding 3 extra floors to parts of the planned building . Complying with the Council's requirements could cost an extra £7m a year for renting additional office space for the next 35-years.

The council also made it quite clear that any revised plans will need to go through a fresh planning application, while some aspects of the current proposals "could be impossible to justify in planning terms".

Figures leaked during the summer to London Health Emergency had indicated that the disaster-prone plan was facing an estimated £43 million per year "affordability gap", which threatens to squeeze budgets for primary care, community and mental health services in the surrounding area.

Gloomy Trust bosses were last year questioning whether the new hospital, originally projected for 2008, will now be open by 2011 – if at all. The eventual costs – and thus the affordability – of the scheme are equally unknown: bids from potential PFI consortia have just been invited.

JEAN BRETT, chair of the Heart of Harefield campaign to keep the hospital open, said "It is clear that these plans are not only undesirable, in that they would break up the established specialist team at Harefield, but also completely unaffordable.

"Even if the architects can find ways of satisfying Westminster's planning team, the capital cost of this scheme is likely to be closer to £1 billion. We want ministers to think again."

JOHN LISTER, Information Director of London Health Emergency, said:

"This scheme has been nothing more than a succession of ever-more expensive blunders from start to finish.

"Every extra day that goes by adds to the costs of accountants, consultants, architects and advisors: ministers must call a halt right now to this waste of taxpayers' money."

Big corridors … shame about the lack of office space: Swindon's Great Western Hospital

■ A NEW formula for calculating the comparative cost of PFI deals against a theoretical "public sector comparator" would have meant none of the first dozen PFI hospital would have go the go-ahead as value for money, according to former minister Stephen Byers.

■ The new formula is included in a Treasury report ***PFI: meeting the investment challenge***, an alternative to the "review" of PFI demanded by last year's Labour Conference. The document trots out the same stale old sources in its attempt to justify PFI as 'value for money'.

■ After a couple of slow years, ministers are expecting PFI deals worth over £3 billion to be signed in the NHS next year (2004).

■ Two investigations were taking place this summer into the £184m PFI-funded Edinburgh Royal Infirmary. One inquiry will look into soaring temperatures of up to 35 degrees in parts of the hospital, which triggered a walkout by nursing staff: the other

UNISON pamphlet on Swindon PFI hospital

Not so great!

THE SHAMBLES behind the glitzy glass facade of Swindon's £132m PFI-funded Great Western Hospital, which opened last December is investigated in a new UNISON pamphlet, just published as we go to press.

Researched for the union by John Lister of LHE, the pamphlet – ***Not So Great*** – consists of an overview introduction, followed by interviews with front-line nursing, clerical and support staff.

The poor terms and conditions on offer to staff from Carillion, the company providing domestic, portering and catering services in the new hospital underline the wider problem of the 2-tier workforce created in the first-wave PFIs.

The new pamplet follows the successful formula of ***Voices from the front-line***, published by UNISON earlier this year, which examined conditions and standards of care in 9 first-wave PFI hospitals.

In each case the question marks over the quality and value for money of support servives is echoed by problems with the size of the building, its design and the poor quality finish to the fabric of the new hospital.

Despite early claims by supporters of the PFI scheme that a new purpose-built hospital would improve efficiency compared with the outdated, much-extended and altered Princess Margaret Hospital it replaced, the Great Western is too small, and relies on portakabins and rented space in a supermarket for office space: it is currently building a number of extensions and add-on facilities.

■ Copies of both pamphlets available from UNISON or from LHE.

Mental health Trusts in deficit as they wait for extra cash

Half of all mental health Trusts were in the red during the last financial year, and half had seen their budgets reduced in 2002-3 compared with the previous financial year.

The findings of a survey by the Royal College of Psychiatrists show that three of the 45 Trusts whose medical directors responded had seen budget cuts of 5% or more, while the overall level of funding across all Trusts fell by 0.8% – at a time when mental health is supposedly a top priority service, and other sections of the NHS are seeing budgets increased.

The pattern of services has also been skewed by Trusts attempting to meet government targets by switching resources and staff from one part of the service to another – notably the expansion of assertive outreach and home treatment teams.

The College's research director Prof Paul Lelliott has warned that mental health Trusts are being obliged to make savings that help pay off deficits elsewhere in the NHS, while cash released from "efficiency savings" is "re-badged" to seem as if it is new money to meet NHS Plan targets.

This report followed one by the Sainsbury Centre which found that two thirds of the 18 Trusts whose finances were examined were running a deficit by the end of the last financial year, ranging from just £1,000 to £5 million.

The pressure group Rethink has claimed that of just over £1 billion announced as new spending on mental health since 1998 only around £750m is traceable as new money leaving the Department of Health, and much of this has vanished into the general pool of new money for the rest of the NHS over the same period.

Its chief executive, Cliff Prior says: "The picture is muddled and confused by double and triple cash counting, multiple public announcements of the same new money, the failure to transparently earmark all the extra funding as it is released and the backloading of spending plans to a 'year three' that never seems to arrive."

■ Berkshire Healthcare Trust has run up a deficit of almost £12m, and is planning to cut psychotherapy services and close a day centre as part of an emergency package of cuts to reduce the shortfall to £3.8m.

■ Mental health services in Glasgow are among those hit by a massive £11m cuts package carried through by the Greater Glasgow Health Board. Homelessness and alcohol projects are to be scrapped, and £1.5m lopped from mental health services. The Board claims implausibly that it still plans to put an extra £1m into children's mental health teams next year.

Counting the cost of mental illness

A shock report by the Sainsbury Centre for Mental Health has totted up the cost to the nation of mental illness – and found it came to a staggering £77 billion in England alone.

A quarter of the population can expect to be affected directly or indirectly by mental health problems, and the Sainsbury estimates include the value of days lost from work as well as the costs of care for mental illness sufferers.

An estimated £23 billion was lost to the economy last year because people were unable to work as a result of mental illness. This is despite the fact that 39% of adults with mental health problems are unemployed.

The bill for care from the NHS, social services, private organisations, relatives and friends was another £12.5 billion.

On top of this the Sainsbury researchers calculated a cash value for the human costs of mental illness, including reduced quality of life and lives lost through suicide – and came up with a total of almost £42 billion.

Scandal as patients wait months for discharge

THE PLIGHT of frail elderly patients marooned in hospital beds for lack of suitable nursing home accommodation or support for them to live at home has frequently been headline news.

But a recent survey of delayed discharges from mental health beds, which revealed extensive delays resulting from a chronic shortage of supported housing facilities in London has attracted far less attention.

Year long wait

More than half of the residents in 18 projects across just three London boroughs had been forced to wait at least a year before being discharged to supported accommodation: a third had waited up to six months.

In two of the boroughs housing shortages were so severe that some mental health clients were being placed outside the borough.

Problems included gaps in provision especially for those with particular needs, and staff shortages among social workers and community psychiatric nurses, which undermine the continuity of care.

The joint report was produced by the Sainsbury Centre with the Greater London Authority, the Association of London Government and Advocacy Really Works.

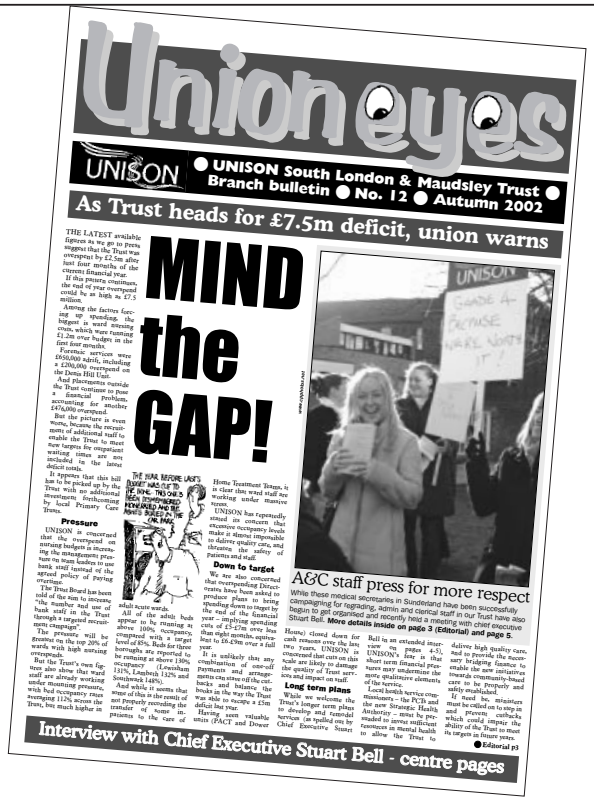
The findings confirm the picture of under-investment and neglect of this key area of psychiatric care that emerged from the UNISON 1999 survey 'The Care Gap', researched by LHE.

The report calls on the government to allocate funds that reflect London's unique demands for mental health care: but the danger is that once again mental health will be fobbed off with warm words and more promises of investment which has yet to materialise.

UNISON

South London and Maudsley Health Branch

Campaigning with LHE to keep mental health on the agenda


Union eyes

UNISON ● UNISON South London & Maudsley Trust Branch bulletin ● No. 12 ● Autumn 2002

As Trust heads for £7.5m deficit, union warns

MIND the GAP!

A&C staff press for more respect

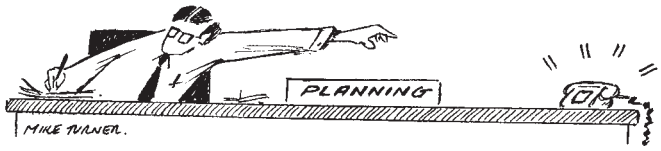
Interview with Chief Executive Stuart Bell - centre pages

BRIAN LUMSDEN Secretary, **LEE ROACH** Chair

Union office, Bethlem Royal Hospital, Monks Orchard Rd, Beckenham, Kent BR3 3BX

New market-style reforms

Foundations of a financial flow fiasco



THE DEFEAT for the policy of Foundation Hospitals suffered by ministers at Labour Party conference will not stop them forging ahead with this and other unpopular policies to "reform" the NHS.

The government seems to be thumbing its nose at its supporters in the unions and across the country, and deliberately recreating the chaos and bureaucracy that caused such havoc in the Tory "internal market"– and which New Labour promised to end in 1997.

The Tories brought a grim legacy of spending cuts, bed closures, soaring waiting lists, privatisation of hospital ancillary services and of much care of the elderly.

This was followed in the 1990s by the mayhem and inefficiencies of a fragmented market system in which Trusts were forced to compete with each other, purchasers made life misery for providers and the wealthiest GPs coined in extra cash as "fundholders".

New Labour has certainly begun to pump more money in to the NHS – and has brought waiting times down: but there are real dangers in the new system that is taking shape, which involves:

- funding hospitals "by results",
- renewed competition between foundation and non-foundation Trusts,
- increased use of private profit-seeking hospitals,
- and billions being committed for PFI-financed hospitals over the next 30 years.

All of these policies will increase costs, weaken the NHS as a public service, and siphon much of the extra spending out of patient care and into the pockets of shareholders.

In an eerie echo of the warnings of Tory health chiefs as they launched their internal market in 1991, Department of Health bureaucrats now admit that the funding reforms alone, which will force Trusts to cut the costs of care to a new 'reference price', could force some Trusts deep into deficit – and they will not be bailed out.

By implication the losing Trusts could go bankrupt, with disastrous consequences for local patients and their staff, when the new scheme swings into action from 2004-5.

The problems do not just affect one or two isolated Trusts. First estimates suggest that on present performance as many as 70 Trusts could lose as much as 25% of their income under the new system, while 150 Trusts would face deficits of more than 9%.

One teaching hospital calculates it would have to cut its costs by £66 million a year. Specialist hospitals with more complex caseloads may find it impossible to meet reference prices.

By contrast some hospitals whose costs are currently below the reference price stand to coin in hefty surpluses, and those gaining up to 9% would be allowed to keep the extra cash.

Bob Dredge, the programme manager overseeing the new policy insists that "there will not be cuts in services." He told the *Health Service Journal:* "It is about shifting the money around. I certainly don't think [making efficiency savings of up to 9%] is impossible."

It's not clear whether Mr Dredge has ever worked in a hospital, but is obvious he has not realised how hard it has been for Trusts to squeeze savings of as little as 2-3%.

Ministers clearly believe that market-style measures along these lines can improve efficiency: but the most marketised, privatised health care system is the USA, where admin costs in the private sector consume up to 30% of spending – a staggering $300 billion each year.

Those European health care systems which split purchasers from providers and involve the public sector buying services from private hospital are twice as expensive to administer as the NHS.

Market models and the "entrepreneurialism" of foundation Trusts have nothing to offer but more bureaucracy, more duplication and waste of resources, and more frustration for health workers, whose views and commitment to public services are being ignored.

NOC debts could knock back foundation bid

New questions are being asked over the viability of at least one foundation trust contender, Oxford's Nuffield Orthopaedic Centre.

The NOC was an early applicant for Trust status, which it used to expand its private beds to make it one of the Trusts most dependent on income from private work, deriving over 10% of its income (almost £5m a year) from commercial work.

But the NOC's finances have lurched into the red this year, notching up a shortfall of almost £500,000 by June – partly driven by the cost of using agency nurses to fill vacancies.

If the Trust does not resolve its financial deficit, it could lose one of the three stars it needs to qualify for Trust status. Four leading contenders for foundation status were ruled out of the running during the summer after losing 3-star status.

Beware "Genetically modified PFI"!

Don't get into this dodgy LIFT!

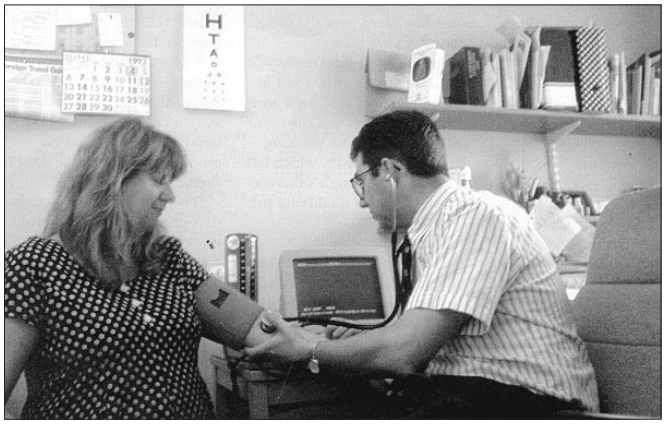
UNISON has branded the new mechanism for injecting private profit-seeking corporations into the financing of primary health care facilities as "genetically modified PFI".

A detailed pamphlet on "Local Initiative Finance Trusts" (LIFT) has been researched for the union by the Democratic Health Network, and it sounds a warning to local campaigners that these schemes are on the spread – and once set up, they will be a permanent fixture.

The first wave of LIFT schemes under discussion add up to £1 billion, two thirds of which comes directly from the private sector, which will retain a stake in each local project through a local company or Liftco.

60% of the shares and of the board in each Liftco will be held by private sector investors, 20% by the Department of Health and its partly-owned pro-PFI organisation Partnerships UK, and 20% by local public sector "stakeholders" (such as Primary Care Trusts and local authorities).

But a long-term snag is that the public sector 'partners' joining a Liftco have to sign a permanent "exclusivity agreement" – giving the new company the exclusive right to provide any new services or facilities that they may require: LIFT is a commitment not for one project, but for a lifetime.



New GP premises could be a nice little earner for corporate investors

Disadvantages

Among the disadvantages of the new set-up is that it specifically aims to attract the interest of large commercial organisations – including those providing private health insurance, and pharmaceutical companies seeking new markets and outlets. This raises important issues of accountability.

But it's not just the private sector getting its talons stuck into the juicy flesh of the NHS at primary care level: LIFT also transforms the public sector bodies involved, creating the potential for new conflicts of interest, and moving from the culture of public services to make primary care more like a business.

As the pamphlet points out: "The creation of the LIFT scheme also means that for the first time NHS and other public bodies will directly hold shares and directorships in companies that are operating for profit."

But although many local public sector organisations appear to have accepted that LIFT is the only show in town for financing new projects, other alternatives are being considered by some PCTs.

There are possibilities which do not involve a permanent privatisation of key primary care facilities: some areas could consider using the proceeds of land sales to fund a public sector alternative, or a partnership with non-profit or voluntary sector organisations instead.

The process of establishing a LIFT scheme can easily take two years – but it is important that the assumptions and proposals are challenged from the beginning.

The public sector organisations will need to begin by drawing up a Strategic Services Development Plan: they then have to advertise for private sector partners, shortlist applicants, and select a preferred bidder.

By this stage, any element of competition between private sector organisations has been eliminated: the preferred bidder is in a very strong position to secure favourable terms, knowing that if they pull out the public sector organisations will be left stranded.

Disclosure

Local campaigners and unions should be demanding the fullest disclosure of anticipated costs of financing, profit margins, and the implications for any staff involved. They must demand full details of the costs and duration of any leases included in the LIFT deal, a genuine comparison between these and existing costs, and evidence to show whether or not the scheme is affordable without damaging local services.

Wherever possible, campaigners will want to avoid local public sector organisation signing up to these schemes. This LIFT does not take the NHS upwards, but down into the grimy world of private profit.

■ ***LIFT: A briefing for non-experts*** is available from UNISON.

Mega PFI put on hold

Trust bosses at the giant Barts & the London hospitals in the East End have postponed a decision on which consortium should pick up the mega-contract for the PFI-funded rebuild of the Royal London Hospital in Whitechapel.

With refurbishment work at Bart's Hospital, the scheme was last costed at a whopping £620 million-plus – and is certain to cost more before any final deal is signed.

Two consortia are in the frame for this, potentially the biggest hospital scheme in England – Skanska/Innisfree and Renaissance.

But the City & Hackney CHC is complaining that in place of the open process of consultation which they had expected and asked for, the Trust has been holding closed meetings, with large amounts of information classed as "commercially sensitive".

The decision, aptly described by the BLT chief executive as "one of the most important decisions the Trust will ever make" will be taken at the end of October.

20 years on – and still campaigning!

AUTUMN 2003 HAS BROUGHT the 20th anniversary of London Health Emergency, and we are hoping to to go into our third decade by stepping up the campaign against the restoration of the "internal market" system, Foundation Hospitals, PFI and privatisation in all its guises.

So it's a big thankyou to those union branches that have taken out adverts to help us fund this issue – and we urge all affiliated organisations to consider taking an advert in the next issue, at the end of the year. A full page is £480, 1/2 page £250, 1/4 page £130, 1/8 £70, 1/16 £35. Send us your artwork, or just the text you want in your advert and we can design one for you.

But remember LHE can also help your organisation in campaigning – developing detailed and researched responses, or campaigning newspapers, newsletters and other publicity.

KEEP US POSTED with your local news: 020 8960 6466, or

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